Life Care Corporation Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Life Care Corporation Limited is a residential care home providing personal care that can support a maximum of 44 people. Many of the people were living with dementia. At the time of the inspection 30 people were supported at the service. Two of whom were away from the service during the inspection.

The service is split into two wings, within a large detached home. Each wing accommodates people across three floors. A communal lounge / dining room is located within each wing, with communal grounds offering access to outside space.

People's experience of using this service and what we found
Concerns related to medicine management had not been resolved since the last inspection. Covert medicines were administered without the correct guidelines in place. Stocks of medicines were unaccounted for. Double signage was not completed where medicines were handwritten on administration documentation. There were concerns related to as required medicine guidance, that could lead to incorrect medicine administration.

There were concerns related to the management and prevention of infection control. Clinical waste was not correctly and securely stored. This had spilled onto the external premises tarmac, within the bin storage area, that was left open and accessible. We found concerns related to storage of foods.

Risks related to people were not always mitigated. Call bells had been removed from people's bathrooms and communal areas, without measures being implemented to manage the risk. Risk assessments in place did not accurately advise of action to take if the risk should occur.

Whilst it is recognised that the provider had made changes to the environment to make it more dementia friendly, issues remained prevalent. Concerns pertaining to room identification had not been picked up although people were known to enter other people's rooms. Risks related to lack of handrails were identified at this inspection and at the last. One bedroom did not have a light switch that could be accessed from the room. The person would need to exit their room in order to turn on or off the light leading to potential risk of fall not identified in the person's care plan.

People's dining experience remained of concern. Lack of choice for seating, poor tableware and choice of foods meant people were not being supported to have their meal preferences met.

Care plans had been rewritten and reviewed since the last inspection but were not person centred. Conflicting information was reported in the records which meant people may not be supported in the most appropriate way. Staff recording was inaccurate and ad hoc therefore an accurate picture of support could not be determined.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not support the MCA.

Governance remained an on-going concern following on from the last inspection. Audits, although completed, were ineffective in accurately capturing information. The registered manager, as a result, was unaware of the issues identified during the course of the inspection.

Staff received comprehensive training that was delivered by an external professional. Staff reported being supported and received regular one to one discussions with their line manager.

Interactions between staff and people were dignified and respectful. People reported staff were always polite and maintained their privacy whilst supporting them.

Safeguarding concerns were correctly reported to the Commission and to the relevant agencies. Staff had a comprehensive understanding of how to report and manage concerns. Sufficient staff were deployed to keep people safe from harm. Recruitment processes ensured people were supported by staff who had been appropriately screened and vetted.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Inadequate (supplementary report published 2 October 2019) with a number of breaches identified. As a result the service was placed in special measures. We imposed conditions on the provider's registration in September 2019 that they must ensure: a) people receive person centred care that is reflective of their personal preferences and choice (b) care plans and risk assessments are sufficiently details and are person centred outlining how staff are to support people (c) people are supported to participate in activities that they are interested in (d) the premises are suitable for supporting people living with dementia (e) effective audits and analysis of systems and processes is implemented to ensure improvement (f) Effective systems are in place to ensure safe medicine management, records are reflective of people's needs and kept up to date, and health and safety is appropriately met. The provider completed an action plan after the last inspection to show us how they would meet these conditions. A monthly report was sent to the Commission detailing progress. At this inspection not enough improvement had been made or sustained by the provider, therefore the service was still in breach of regulations. The service retains an Inadequate rating.

Why we inspected
This was a planned inspection based on the previous rating. This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We have found evidence that the provider still needs to make improvements. Please see all sections of this full report to identify areas where improvement continues to be required. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has not changed. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Life Care Corporation Limited on our website at www.cqc.org.uk.

Enforcement
We have identified continued breaches in relation to Regulation 9 (person centred care), Regulation 12 (safe care and treatment), Regulation 15 (premises and equipment) and Regulation 17 (good governance) . The service was also in breach of Regulation 11 (need for consent).

Please see the action we have told the provider to take at the end of this report.

We are mindful of the impact of Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating. In addition, we will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Life Care Corporation Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was completed over two days. On the first day two inspectors were present. On the second day only one inspector was in attendance. A specialist advisor – a registered nurse with specialism in dementia care and medicines was present for both days of the inspection.

Service and service type
Life Care Corporation Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider did not complete a provider information return. This is information we require providers to send us to give some key

information about the service, what the service does well and improvements they plan to make. The service was in special measures and the provider was sending the Commission monthly updates on the action plan that had been created following the last inspection. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who use the service and two relatives about their experience of the care provided. We spoke with nine members of staff including the group operations manager, the registered manager, deputy manager, senior care workers, care workers and the newly appointed maintenance person. We had an opportunity to speak with two visiting health professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included nine people's care records and multiple medication records, including 28 medicine administration records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, quality assurance surveys and governance audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data that was forwarded as well as the business continuity plan. We spoke with a further two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
A condition was placed on the provider in September 2019, that detailed the need for risks to be managed, specifically in relation to pressure ulcer management and nutrition and weight management.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12. Whilst the provider had made some changes to risk management, insufficient changes had been made specifically around nutrition and weight management which impacts pressure ulcer management. This meant this condition had not been met, this is an offence that is prosecutable under the powers of the Commission.

● On day one of the inspection we found that all en-suite bathrooms, communal bathrooms and communal rooms had call bells either removed or cut. We raised this with the group operations manager and registered manager. The group operations manager told us a new call bell system was being installed however he was unable to provide a date for this. This meant the provider did not ensure a system to respond to people and risks related to their care and health was in place. No alternative system was in place for people to call or seek assistance.
● The provider had not completed adequate checks or appropriately risk assessed the environment to ensure it was safe and hazard free for people and staff. Some of these concerns had been raised at previous inspections. For example, a steep slope linking both wings of the service was accessed by people and the flooring was slippery. There were no hand rails for people to use and prevent them from falling. The external premises had steep slopes, insufficient handrails, mats that were curling and areas where water was accumulating. This area was accessible to staff and people. The registered manager had not completed any risk assessments and had not taken any action to mitigate the risk of people and staff falling and injuring themselves.
● During the inspection we were hit twice by the solid door that linked the wings. The door's risk assessment was completed in September 2019. The risk assessment documented that the risk was mitigated by "opening the door slowly". However, the assessment did not indicate any immediate mitigation or prevention actions to avoid people and visitors being hit by it. Reference was made to the door being fitted with a "glass hatch" when the area was to be refurbished. However, there was no indication of when this would be completed. There was no way for anyone opening the door to know if someone was on the other

side. No action had been taken by the provider to resolve this.

● Bedroom doors were not fitted with fixtures to enable people to safely keep the door open should they wish to or to enable them to move independently without assistance. This meant that if people lodged the door open, they were restricting fire door closures. The environment risk assessment recognised that the doors were heavy and recorded the need to ensure appropriate fixtures to prevent "fingers being caught" in the doorway. This was documented on 22 January 2016 and reviewed annually by the management team. The most recent review having been completed on 13 January 2020. Although the risks were identified nothing had been done to mitigate and manage the risk by the provider.

● The environment risk assessment identified the need for securing furniture to keep people safe from accidents and injuries in their room. For example, bedroom furniture was not secured to the walls. This meant that when wardrobe doors were opened, they swayed side to side and back and forth. People were at risk of injury from furniture that was not secured to the walls.

● There were no records of water temperatures being recorded before people were being given personal care, although provider policies stated the need to record this. Water temperature checks were completed on a weekly basis. However staff were not following company policy and checking water temperature prior to supporting with personal care. No records were maintained of checks that should have been completed prior to supporting people with personal care. Thermometers were not available in bathrooms. We spoke with the registered manager who acknowledged that there was no evidence to illustrate staff had completed the water temperature checks. However, service checks of The TMVs were not available or provided following the inspection.

● We found care plan and risk assessments had been completed for people. However, these were not accurate or reflective of people's specific needs or risks. At the last inspection we found that staff were not accurately utilising the Malnutrition Universal Screening Tool (MUST). This is a tool used to determine people's risk of malnutrition. At this inspection we found that this remained the case. Where the MUST had determined a person was at high risk of malnutrition proactive measures had not been implemented to ensure people were eating or drinking sufficiently. For example, whilst fluid intake was being monitored and a running total was obtained this was not measured against the required amount. This meant that staff were not aware of how much the person needed to have drunk in a 24-hour timeframe to ensure they were well hydrated. We found the same issue with regards to the monitoring of what people were eating. We spoke with staff to determine how much people should drink and how much had been taken in, they were unable to provide accurate details on this. Records indicated significant shortfalls, which went undetected therefore unactioned by staff. People were placed at risk by not being given sufficient fluids. People were being weighed and no correlation was being made between weight and MUST score. Weight can impact on a person's pressure ulcer management. Weight can directly impact skin integrity, as can poor hydration. The lack of correlation between weight, MUST and food / fluid intake meant the registered manager potentially put people at risk of developing pressure ulcers. However, at the time of the inspection no one had a pressure ulcer.

● We looked at records of repositioning for people who had been identified as high risk of poor skin integrity. We found for four people's records indicated they had not been repositioned in accordance to the frequency identified in the care plan and risk management plan, with gaps of up to 14 hours. We cross referenced this with the people's personal care logs and found no records of such care and support provided. The manager did not have a system in place to manage people's skin integrity safely. We spoke with the registered manager and staff regarding this and they were unable to provide any clarity on the situation. The registered manager advised they would be investigating this.

● One person had epilepsy and they had a medical care plan that referred staff to an epilepsy care plan to manage and mitigate risk of harm, should the person have a seizure. No epilepsy plan existed. Staff had not received specific training in epilepsy management. However, after the inspection the provider shared evidence with us that staff had undergone a 3 hour first aid course which included first aid for people having

a seizure.

The provider continually failed to mitigate and manage risk appropriately. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At our last inspection the provider had failed to protect people from the risks associated with unsafe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection therefore the provider remained in breach of regulation 12.

● We found that five people were being given medicines covertly, although staff only highlighted three when we asked if anyone was being administered covert medicines. We found no evidence that these people's capacity to consent to covert medicines had been assessed or that a best interest decision had been made to administer medicines covertly. Guidelines were not in place to tell staff how to safely administer covert medicines. This meant that at least five people may have incorrectly and unsafely been administered covert medicines.
● At the last inspection we found that PRN (as required) medicine protocols were not in place for all people who required these. At this inspection we found that whilst PRN protocols had been written for people, these were not detailed enough where more than one PRN medicine was being given for the same condition. For example, two people were prescribed two different painkillers, with varying doses and strengths. The PRN protocol guidance detailed indicators of when each individual medicine were to be given however it did not indicate what the first medicine option for pain relief should be. This meant that people may be at risk of not having their symptoms managed effectively.
● One person had been prescribed thickeners as a PRN. Thickeners are added to liquids to enable a person with swallowing difficulties to swallow the liquid safely. Staff had not picked up that this was not PRN rather a continuous requirement for the person. There was no evidence that this was being given with everything drink. The person was therefore at risk of choking. This was rectified during the inspection. Other PRN guidance was not detailed enough where people did not have the ability to express the need for the medicine. Signs people may display that would indicate the need for a certain medicine were not identified and documented to help staff to determine when to give the medicines.
● Staff did not ensure medicines were not reviewed as required. We further found that one medicine that was to be administered as a short course for two weeks, followed by a medical review, was still being administered four weeks later. A review had not been completed, and staff and the registered manager had not picked up that the medicine should have been stopped two weeks prior to the inspection. Staff immediately called the relevant health professional and reviewed the medicine. This was changed to regular medication following our intervention.
● During the inspection we found there were stock level discrepancies specifically in relation to Paracetamol and Atorvastatin. Over 50 tablets were unaccounted for. Following the inspection we were forwarded an investigation that suggested the discrepancy was as a result of error in recording. No action was evidenced to prevent a similar occurrence. The investigation was neither dated nor signed to indicate when the issue had been resolved.

The provider continually failed to protect people from the risks associated with unsafe management of medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed a medicine round and the member of staff completing this ensured they spoke with people, explaining what the medicine was for before administering. Medicines were appropriately signed as given within the medicine administration record (MARs).
● Where specific measures needed to be taken before medicine administration, records were completed to show correct procedures had been followed. For example, monitoring a person's pulse prior to giving medicines.
●All stock medicines were correctly stored. MARs contained people's details including a photograph ensuring the correct person was administered the medicines.

Preventing and controlling infection
● We found that the service was not protecting people from the risk of infection. A number of issues were identified during the course of the inspection, that were brought to the attention of the registered manager and the group operations manager. The infection control audit, although completed, failed to identify concerns. The last audit was rated outstanding, with a 94% compliance score.
● We found that both clinical and general waste was not stored correctly. External general waste bins were overflowing; clinical waste was piled on the ground due to the bin being full; the access to the bins was unlocked and unsecure. We brought this to the attention of all senior management on the first day of the inspection. The situation remained unresolved by the close of the second day of inspection.
● We found one bath hoist / seat was very badly stained with a brown residue. The cleaning schedule indicated that the bathroom had not been checked since the previous day.
● A kitchenette on one of the top floors was stained with urine. This area although was not inhabited at the time of the inspection, was open and accessible to people living in the service. The area was heavily malodorous. The bedroom and the open space area was also extremely malodorous. A mattress that had been urinated on and was malodorous had been placed in the mattress store with other clean mattresses. The provider advised that this area had not been cleaned since November 2019, and they were awaiting the local authority to release funding to resolve the matter.
● We found that open breads and cereals were not stored in pest control containers.

The provider failed to protect people from the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Training records indicated that all staff except one had training that was up to date in infection control.
● Personal protective equipment (PPE), including gloves and aprons was available for staff to help prevent the spread of infection.

Learning lessons when things go wrong
● The service maintained records of all accidents and incidents. Forms were appropriately completed, and an analysis concluded to determine the cause of the incident. Where possible, action was taken to prevent a similar occurrence.
● The registered manager shared information with staff to ensure lessons were appropriately learnt.

Staffing and recruitment
● Sufficient staff were deployed at the service to meet people's needs. Staff, people and relatives reported

they felt adequate staffing numbers were present to ensure people were safe. However, it was noted that staff were often task focused and that language was occasionally a barrier with communication. One person we spoke with said, "It's got better, however not all staff speak English well, and that can make it difficult to understand things." The registered manager advised that staff were being supported to attend English courses. Staff told us this improved "confidence and communication."

● People were kept safe by adequate recruitment processes employed by the provider. Checks were completed to ensure people did not have a criminal record, gaps in employment explained, character checks completed and records maintained of interviews to ensure staff were appropriate for the job.

● We did note that gaps were present between education and employment. We spoke with the registered manager regarding this. We were assured that staff recruitment files would be checked and where necessary additional information gathered and evidenced.

Systems and processes to safeguard people from the risk of abuse

● People reported feeling safe living at the service. One person we spoke with said, "I know I am safe here. They look after me well."

● Staff had received training in safeguarding. They were able to accurately describe what constituted abuse and what protocol to follow if they suspected abuse. Staff were able to name external agencies that were to be contacted, including the local safeguarding team and the Commission.

● Staff told us that they would not hesitate to blow the whistle if they felt the provider or manager was not taking their concerns seriously.

● We had received all notifications as required by the registered manager of all safeguarding issues. Whilst these were appropriately investigated, it was noted that risks were not always mitigated. For example, medicine errors continued. These had the potential to have an impact on people's welfare when medicines were missed frequently.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Adapting service, design, decoration to meet people's needs

At our last inspection the provider had failed to provide suitable premises for the purpose for which they were being used. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
A condition was placed on the provider in September 2019, that detailed the need for the environment to be effective to meet the needs of people living with dementia.

Not enough improvement had been made at this inspection therefore the provider remained in breach of regulation 15. Whilst the provider had made some changes to the environment they were insufficient. The premises remained unsuitable for people living with dementia. This meant this condition had not been met.

- The premises were not suitable for people living with dementia. Whilst the provider had sought guidance and referred to research to implement some of the changes, issues remained prevalent. These could create hinderance for people living with dementia. All the work had not been completed. Some doorframes had been left half painted. Light switches did not consistently standout from the wall. The inconsistency in the approach including décor within the home, created greater confusion to people living with dementia as they were expected to recollect décor pattern differences.
- We found that bedroom doors had all been coated in laminate to replicate illustrations of front doors. These were varying in colour, from red, green, yellow to blue. All depicted a letterbox. This however, was for illustration purposes only. No door number was visible. This meant that people could become confused when trying to access their room. Each bedroom had a memory box located directly beside the door. However, these contained no personal items to the person. Instead posters that were unrelated to the person were posted in the memory box. We noted that one care plan detailed concerns where a person repeatedly entered another person's room due to confusion relating to the door, specifically that their door had the same appearance as the other person's door. The illustration of the letterbox could lead people living with dementia to become frustrated as they try to post items through the door. The lack of numbers on bedroom doors heightened confusion as one corridor had more than one door that was the same. We raised with the registered manager and senior management team concerns that the bedroom doors could lead to further potential problems, given that there were no identifiers visible.
- The provider began to replace the posters contained within the memory boxes, replacing these with photos of the person whose room it was, as we completed the inspection on day two. We were assured that

all memory boxes would be updated.
● At the last inspection we found that bedrooms were lacking personalisation. At this inspection we found there were no significant changes made. Rooms were predominantly clinical with white walls, a bed, wardrobe and beside cabinet.
●The registered manager acknowledged that work was yet to be completed with some bedrooms where the process had yet to be started. We noted from the maintenance book and through observations that one bedroom that looked out into the garden had no privacy. This was identified in November 2019. The registered manager had not ensured this issue was rectified.
● None of the bedroom doors could be left open safely should the person want this. We noted that all bedroom doors had automatic closures, as a fire safety feature. However, these restricted people's freedom of movement. The doors were heavy and would not be safe or possible for the person to open independently if using a mobility aid.
● One bedroom that had an en-suite located immediately outside the bedroom did not have a light switch inside the room. If the person were to wake at night, they would be unable to safely get to the door. The lamp was also not placed within proximity.
● Although signage, had been introduced in the service, it was inconsistent. Bathrooms or toilets that were for staff and visitors had signs. These were locked. We spoke with the registered manager querying the need for signage on rooms that were not to be used by people. This could lead to confusion. Where signs were used, these were not always placed at the correct height for people to easily read. Bedrooms had door numbers located on the top of the doorframe.Signs that were directing service users to different locations (e.g. dining room, lavender walk etc) were not all at the correct height. This was also identified as an area of concern at the last inspection.
● At the last inspection we found the provider was not following best practice guidance in relation to dementia friendly environments. At this inspection we found that the provider had been unable to fully implement best practice guidance, particularly in relation to the colour the laying of tables and type of crockery used at mealtimes. This meant that people living with dementia were not supported by the environment to be as independent as possible.
● A corridor leading between the two wings of the service, accessible by people, was unsafe. Doors did not offer any glass feature to enable people to see if anyone was coming. Handrails were not fitted to enable a person to safely descend into the adjoining wing where a slope was present.

The provider continued to fail to provide suitable and safe premises for the purpose for which they were being used. This was a continued breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law and Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider did not ensure person centred care was provided to people that was appropriate and met their needs and personal preference. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
A condition was placed on the provider in September 2019, that detailed the need for all care plans to be written and reviewed, reflecting people's specific care needs.
A separate condition focused on pressure ulcer management (also looked at within Safe).
A third condition placed on the provider specifically focused on the needs of people being met in relation to their dining experience.

Not enough improvement had been made at this inspection, therefore the provider remained in breach of regulation 9. Whilst care plans had been written and reviewed, these were not accurately reflective of people's needs. Dining experiences continued to be negative for people. This meant these conditions had not been met.

● At the last inspection we found that care plans were not personalised. Details of people's choice and preference was not recorded to ensure staff delivered care in line with people's preferences. At this inspection we found that whilst the provider had introduced a new electronic system to record and correlate information about people, information was not always accurate. Details recorded did not enable effective outcomes for people. For example, in one person's file we noted three contradictions related to level of support to offer with personal care. We spoke with the registered manager regarding this, who acknowledged that the lack of accurate and consistent information could cause problems for new staff and increased anxiety for the person.
● We noted that relatives' feedback was regarded and relied on more than information the person provided to the service about how they wished to be cared for. The registered manager advised they wished to keep the family involved as much as possible with the care people received. We could see no evidence that people had consented to relatives making decisions about the care that was provided for them, or that relatives had the appropriate legal authority to make these decisions.
● We noted that many files had oral care assessments in place. These detailed information such as whether the person had dentures, cleaned their teeth independently or required support. However the information from the assessment was not used to write an accurate oral health care plan, that guided staff on how to support people with dentures or their own teeth. This meant that staff did not know how to support people with their oral health care. One person's file suggested that the person had not been supported on ten occasions with oral care in January 2020. Another file indicated eight gaps. Research has found that more than half of care home population nationally suffer with tooth decay, therefore oral care is an integral part of the support people require. Staff were unable to advise if support had been provided.
● Whilst we observed people being offered food and drink throughout the day, there were concerns related to staff's understanding of good nutrition and hydration. For example, one person's record indicated the fluid offered over the course of ten days was well below acceptable amounts. On eight days fluid offered per day was below 950ml, with the maximum intake per day falling below 585ml. The NHS recommend minimum total fluid intake is 1500-2000ml. Insufficient fluids can lead to poor skin integrity, dehydration, swallowing difficulties and complications with pre-existing conditions of diabetes and dementia. A similar pattern was noted in a further four files reviewed. People at the service were at risk of developing pressure sores. The tissue viability nurse did visit people at the home, where pressure sores developed.
● We completed observations over lunchtime of people's mealtime experiences. We found that people were seated at the dining tables significantly ahead of lunch being served. In one wing people were sat in excess of 20 minutes prior to meals being brought out. This meant that people living with dementia could get confused or frustrated having to sit at a dining table for so long before the actual food was served. We observed one person during lunch serving on day two become highly anxious. This was impacting negatively on other people sat at the table, who too became vocal and anxious. One member of staff tried to reassure the person. The person was sat at the table 20 minutes before food was being served. Main meals were served already plated. No visual aid was shown to people to enable them to make an informed choice of meal options during the serving. Although menus that had pictures to illustrate the meals, were placed on the tables staff did not show these to people to encourage them to choose.
● Tables in one wing only sat a maximum of eight people, although more people needed to be seated. This meant that people were not able to make a choice of where they sat to eat and with whom.
● Day one meal time observations showed that tables were laid without table cloths, condiments and basic items, for example napkins. On day two we found that table cloths were used although condiments

remained missing.
● People gave mixed reviews of the mealtime experiences. One person reported, "I only eat the puddings here, I can't fault them, I have a bit of a sweet tooth..." Another person said, "It's okay, nothing amazing, it keeps you alive."
● We noted that menus did not offer hot breakfast choices, other than porridge or toast. Audits from November 2019 and meeting minutes from October 2019 identified the need to introduce "homemade hot meals" and "cooked breakfasts" to the menu. At the time of the inspection, these had yet to be introduced. This meant that people were unable to have a varied breakfast choice that met their preferred taste.

The provider failed to ensure that person centred care was appropriate and met the needs and personal preferences of people. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found that people were potentially being deprived of their liberty as records were not accurately maintained to establish otherwise.

● Staff did not have a clear understanding of how to apply the principles of the MCA in live situations even though they had training in MCA. For example, staff did not understand how to assess whether a person had capacity to decide whether to take a particular prescriptive medicine. Decisions were made on behalf of people without clear evidence of how the rationale was reached. No best interest decision meetings were recorded for four people.
● Similarly, we found that for another person who was deemed to have full capacity following a MCA assessment, a best interest decision meeting had taken place after the assessment by the service. The best interest document read "[the person]does not have capacity to make care decisions." We discussed this with management who acknowledged the best interest meeting should not have occurred. They concurred potentially the person may have been restricted to make decisions on matters they were fully competent to do on.
● Staff we spoke with said, "Mental capacity is about choice, for example what they eat or wear." Another staff said, "It's making sure we tell them we are going to help them and ask before we do."

The provider had not ensured that care and treatment was provided with consent from the relevant person, furthermore, the provider had not followed the principles of the MCA. This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● An effective system to ensure staff received relevant training had been developed by the provider. We saw evidence of training programmes that were scheduled for the year ahead, as well as the training matrix. This indicated that all the provider's mandatory training was complete.

● Competency assessments had been completed to assess staff knowledge and practice of the training topics. Champions were being developed for key topic areas to further support staff.

● All new staff received an induction programme that worked in line with the Care Certificate. This is a set of 15 standards that new health and social care workers need to complete and illustrate a comprehension of when working in the care sector.

● Staff we spoke with reported, "Since the manager has been in post we have had excellent training." Another staff member said, "… anything you wish to learn about, that is relevant, [registered manager] will arrange."

● Staff reported they received frequent supervision, "both formally and informally". Staff reported it was effective in that it allowed them to see how they had progressed and areas to improve on.

● Appraisals were to take place annually. These were set up and arranged in the diary.

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live healthier lives, access healthcare services and support

● We saw health professionals visit the service during the inspection, as well as people being supported to attend medical appointments. One person we spoke with said, "They usually tell you in advance, but today they just got me ready for my hospital appointment. I didn't even know I was going."

● Staff confirmed that referrals were made to the relevant teams as and when issues were identified. Professionals we spoke with confirmed that staff were proactive in seeking advice and guidance from external professionals.

● However, we did note that staff did not always ensure they rearranged medical follow up meetings or reviews as required for people. This could lead to the development of potential health concerns. We spoke with senior staff about two separate incidents. One required a community psychiatric nurse to review medicines, whilst another required a potential referral to a tissue viability nurse.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

At our last inspection the provider had failed to consistently deliver appropriate person-centred care and treatment that was responsive to people's needs. This was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection within this domain, therefore the provider was no longer in breach of regulation 9 within caring.

● We found that staff approached and communicated with people compassionately and respectfully. People we spoke with said, "They are very polite, no issues," and, "lovely girls".
● We noted that care plans varied in the information they contained about people's religious and cultural backgrounds. These were dependent on the information families had been able to offer.
● Staff had received training in equality and diversity and were able to explain and provide various examples of how they put this into practice. For example, treating everyone the same regardless of their religious belief, or trying to encourage people to do something independently.
● Not all care plans documented diversity and religious preference, with how the person wished to be supported. The registered manager acknowledged this was an area for further development.
● People were addressed by their preferred name. Staff knew people well and were able to respond to their needs, although acknowledged documentation still required updating.

Supporting people to express their views and be involved in making decisions about their care
●People were not always involved in decisions about their care and able to express their views.
●The updated care plans did not clearly identify if people had consented or were involved in making decisions related to their care. Best interest decision records were not retained for all people where meetings had taken place and the authorised body was involved in making decisions on behalf of the person. This was an issue identified at the previous inspection and remained unresolved at this inspection. We have focused on this further within the effective domain.
● It was unclear if people's opinion was sought on how they wished their bedrooms and the home to be decorated. We spoke with staff who told us that people's history and discussions with relatives had enabled them to judge how to decorate people's rooms. However, when we asked if people were involved, staff were unable to confirm this.

Respecting and promoting people's privacy, dignity and independence

●People's privacy and dignity was not always upheld or respected.

●It was not clear when personal care was being delivered in people's bedrooms. a sign was not placed on the door to inform other staff or visitors of the support being offered. during the inspection we had knocked and waited for a response before opening a door. We found two staff assisting a person with personal care. No one had responded to our knock to inform us they were present in the room. As bedroom doors cannot be left open it was unclear if anyone was in the room. As such visitors may inadvertently enter the bedroom. We spoke with the management team regarding this concern.

● People nevertheless felt that staff maintained their privacy and dignity. We were told, "They cover me up," and, "They knock before they enter my room."

● Staff were able to provide clear examples of how a person needed to be supported whilst maintaining their dignity. We were told doors were closed, curtains drawn, and people were covered. One staff member said, "Always ask before completing task, it keeps people involved, [only] dignified way."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection the provider had failed to consistently deliver person centred care to people that was responsive to their needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
A condition was placed on the provider in September 2019, that detailed the need for all care plans to be written and reviewed, reflecting the need of care to be specific to the needs of people. A separate condition imposed in September 2019 detailed the need for people to be supported to follow their interests and take part in personalised activities.

Not enough improvement had been made at this inspection, therefore the provider remained in breach of regulation 9. Whilst care plans had been written and reviewed, these were not accurately reflective of people's needs. Activities were not personalised and did not enable people to follow their interests. This meant both conditions had not been met.

● An activities co-ordinator had been employed by the service who had developed a number of activities that were group based. We completed an analysis of a third of people's files and found that there were no person specific activities arranged for people individually.
● We observed an activity on day one. We found nine people were sat in the lounge. The activity offered was not the one listed on the timetable. The co-ordinator focused on one person only, involving them alone in the activity. The remaining eight people spent the activity being disengaged and not communicated with, resulting in many falling asleep. However, later in the day we saw a positive activity. People from both wings were invited to "movie time". We observed people appearing to enjoy the film.
● We found that where a person did not partake in an activity, staff did not appear to know how to engage with them. We observed over both days staff sitting with people in the lounge or standing in waiting. Limited conversation and interaction were held with people unless it was task focused. We discussed this with the registered manager who acknowledged this was an area for further development that had been identified.
● On day one of inspection, we noticed people were being taken to their bedrooms, with only two people remaining in the lounge at 19.10hrs. They too were then taken to their room. We spoke with the registered manager seeking clarity, specifically given none of the care plans reviewed detailed what time people wished to retire to bed. We were told this was people's wishes. We found no evidence in people's care files that these options or preferences were explored with people. Daily notes did not indicate that people were asked for consent to take them to bed so early. This was raised as a concern at the previous inspection, and

remained a concern following observations at this inspection.
● Care plans did not evidence people being involved in the development of their care documents. One person we spoke with said, "I don't recall ever being asked how I wished to be looked after." Another reported, "Not to my knowledge. Nothing formal."
● Staff we spoke with emphasised the need for families being involved in care plan development. This emphasis was not in place regarding collecting information from the person. One member of staff said, "of course yes people are involved, but they often can't remember things and their families provide more information."

The provider failed to ensure that person centred care was appropriate and met the needs and personal preferences of people. his was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● At the last inspection we recommended the registered manager develop their understanding of the accessible information standard and ensure it was implemented. Since the last inspection the previous registered manager has left and there is a new registered manager in post.
● We found that information was not presented in a format that would be understandable to people. At the last inspection we noted information was presented to people in small font on white paper. This was still the case. Written menus were in black on white paper. Activities were presented similarly. Where text size had been increased a lot of information was presented to people. For example, the complaints procedure that was located in one of the wings had large handwritten text. However, the amount of detail that this contained was difficult to follow, especially for people living with dementia. Best practice guidance was not followed by the registered manager.
● Care plans documented how people communicated. However, did not include information on how people needed to be supported where information was to be provided. For example, the use of bold text, pictures, etc. Information needs to be available to the person so that they may understand how staff are to support them.

Information was not provided to the person in a format that enabled them to make decisions related to their care This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● The service had a complaints protocol in place.
● We saw that complaints were investigated, and feedback was provided to the complainant as required in line with the provider's policy. However, not all letters and investigations were dated. This meant it was unclear to follow the response to a complaint, where multiple complaints were about the same issue.
● No follow up was completed on complaints where concerns were repeatedly raised. This has been looked at further in well-led.

End of life care and support

● At the last inspection no one was receiving end of life care support. We saw no evidence of how the service would ensure people's wishes at this stage would be met.
● At this inspection we found one person was on end of life care. The care plan was very detailed and recorded the person's final wishes. Information included who the person wanted with them, any funeral arrangements, including the directors, as well as where the person wished to be laid at rest.
● The registered manager advised that all people within the service would have an end of life care plan in place. Information had been requested from relatives on how the service could support people, we were told relatives had not been forthcoming with information.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to have effective quality assurance systems which enabled continuous learning, improvement and innovation. This was a breach of regulation 17 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
A condition was placed on the provider in September 2019, that focused on the requirement of effective audits and analysis of care records, health and safety and medicine management. A separate condition imposed in September 2019 detailed the need for effective systems and processes to be in place that could illustrate effective service improvement.

Not enough improvement had been made at this inspection, therefore the provider remained in breach of regulation 17. Whilst audits were completed monthly these were not highlighting issues or concerns we found during the inspection. Systems and processes were in infancy in relation to service improvement. Evidence was not present of people and relatives being involved in development of plans. This meant both conditions had not been met by the registered persons.

- The registered manager had been registered with the Commission in September 2019, although commenced employment in July 2019.
- The registered manager was overseeing two different registered sites, therefore spent three days at this location and two days at the other. We spoke with the registered manager regarding our concerns related to them not overseeing the service on a fulltime basis, however were advised that they were happy to work longer hours to ensure the work was done. We were advised the new management team structure had been developed around the manager to help support both services. The deputy manager had also been appointed following the last inspection.
- The registered manager and provider had failed to establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- We found that the care and treatment of people was not always appropriate and their needs and preferences were not always reflected in care documentation and guidance provided to staff. People told us that they were not involved in care plan writing. The registered manager, emphasised the need for next of kin to be involved.
- The registered manager and provider had not ensured that the care and treatment people were provided was with the consent of the relevant person(s). Documentation and evidence was not kept up to date.

People reported they were not asked and consulted in relation to their care plans. Staff, although trained, did not have a thorough understanding of the principle of the Mental Capacity Act and how to put this into practice.

● The registered manager and provider did not ensure care was provided safely. We found multiple concerns related to poor medicine management, infection control issues, risks not being mitigated appropriately. These concerns had gone undetected, although had the potential of significant risk of harm to people.

● The provider had not ensured the premises and environment used by the service were fit for purpose. We found that best practice guidance had not been followed consistently to ensure people living with dementia resided in an environment that best supported them.

● Effective systems were not in place to evidence good governance.

● We found that whilst a number of audits were completed at the service, these failed to identify issues that we identified during the inspection. For example, the medicines audit did not determine that covert medicines were being given without the correct authorisation documentation. Second signing had not been completed for handwritten medicine administration records, although best practice guidance issued by NICE outlines: "managing medicines in care homes states care home providers should ensure a verbal or hand-written administration record is created by an appropriately trained person, and should be checked by a second appropriately trained member of staff." The last record seen of the medicine audit was dated 29 November 2019 and scored the service at 96.1% compliant (outstanding).

● The infection control audit scored the service at 94% (outstanding) in December 2019. However, staff meeting minutes raised significant practice issues including soiled pads being carried in corridors without being wrapped for the same period. We further found concerns pertaining to correct disposal of clinical waste, infection control issues in bathrooms and storage of foods.

● The health and safety audit was scored at 75.6% (good) on 3 December 2019. Concerns were identified in relation to the need to secure wardrobes to the walls. This remained outstanding. We completed an audit of the maintenance book. This identified that many issues identified from 13 November 2019 onwards remained unresolved. These included broken light fittings, broken heating in a person's room, broken catch on external door and a leaking small sink (handwashing) in the kitchen. This had not been picked up in any of the audits completed by the registered manager.

● All the audits completed for November 2019 found in the file were rating the service as "outstanding" and "good". Records were not seen for the December audits although reference was made to the scores in the staff meeting minutes from January 2020.

● The registered manager, although had completed walk arounds of the home, had not identified or actioned concerns pertaining to the lack of call bells.

● The clinical waste bin and area was unlocked, with doors open, accessible and spilled at the front of the property. No action has been taken to mitigate the risk associated with this by the registered manager.

● At our last inspection we identified the ineffectiveness of the audits. These had not been updated or amended to enable the registered manager to determine an accurate assessment of the service shortcomings. Whilst audits were completed these were ineffective

Not enough improvement had been made at this inspection. The registered persons failed to consistently assess, monitor and improve the quality of the service in line with their legal obligations and regulations. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff generally reported a positive culture of the home, specifically since the new registered manager had

been appointed.
● The registered manager was available and visible throughout the service, completing walk arounds, when based at this location.
● Whilst the registered manager and staff team tried to ensure good outcomes for people, this was often at the detriment of people's choice and independence.
● Care plans were not individual or bespoke to meet people's specific needs. They failed to illustrate how people wished to be supported.
● People were not enabled to engage in positive interaction and experiences over mealtimes. The layout of the communal spaces did not enable people to talk freely. Chairs were placed alongside perimeters. Insufficient space during dining times meant people did not have a choice of where to sit. We observed one person enter the dining room at 12.52 hours on day one. There was no dining space. The person began moving furniture to make space.
● Poor understanding and practice of the Mental Capacity Act meant that people were inadvertently potentially prevented from doing things that they were able to make informed choice about. By empowering relatives or next of kin, when they legally did not have the authority to make decisions on behalf of individuals, the service placed restrictions on people. The registered manager's focus on ensuring families were involved inadvertently restricted people's choice.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager ensured that they fulfilled their legal duty in the event of something going wrong with a person. We saw evidence of written communication that had been sent to the person or their representative in this situation.
● Correspondence from the registered manager when a specific incident occurred was transparent. The outcome of the investigation was clearly detailed with the person or their representative being given the opportunity to liaise with the registered manager about the outcome.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics and Working in partnership with others
● We received some positive feedback from professionals who visit the service. They said management team were working very hard to develop and maintain partnership in healthcare working.
● The local authority reported that the service was now engaging well, seeking clarity and support where issues were noted. However, the sustainability of improvements remained as an ongoing issue.
● The registered manager evidenced quality assurance surveys, seeking feedback from people, relatives and professionals. A "you said, we listened" was on display, highlighting areas where improvements had been made.
● The registered manager advised this was a long process. A number of improvements and issues were to be actioned. An action plan was currently being developed specifically focusing on these, including how and when each action would be met, with a timescale.
● Team meetings were held frequently that offered staff an opportunity to learn of operational changes within the service, as well as discuss areas of concern related to people and their care. There were concerns related to the wording in the meeting minutes of January 2020. Language and perception of management towards some staff was somewhat negative. We spoke with the registered manager regarding this. Specifically given this was a document available for staff to read and refer to. We were advised that although the document was entitled "Meeting Minutes" and recorded attendees, this was the registered manager's agenda and should not have been stored in the file.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person failed to provide person centred care to people that was appropriate, and met their needs and personal preferences. Where appropriate the relevant authorised person was not involved in making decisions related to people's care that was reflective of their choice. Regulation 9(1)(2)(3)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not ensure care and treatment was provided with consent from the person or the appropriate authorised person. Staff did not have a thorough understanding of the Mental Capacity Act and the importance of working within the principles of this. Regulation 11(1)(2)(3)(4)(5)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

	The registered person failed to ensure care and treatment was provided safely. Risks were not appropriately mitigated, medicines were not managed safely and preventative measures were not employed to prevent and control infection. Regulation 12(1)(2)(a)(b)(d)(g)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person did not ensure the premises were safe and suitable for the purpose for which they were being used. Regulation 15(1)(a)(c)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not ensure that systems and processes were effective in ensuring compliance with the fundamental standards. Risks were not appropriately mitigated, records were not accurate or complete and audits failed to accurately establish risks and areas of improvement. Regulation 17(1)(2)(a)(b)(c)(d)(f)(3)(a)(b)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.